

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

14896

State File No.

LED MAY 2 1953

BIRTH NO. REG. DIST. NO. 181 PRIMARY REG. DIST. NO. 4293 Registrar's No. 15

1. PLACE OF DEATH a. COUNTY Lincoln		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Lincoln	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Elsberry		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Elsberry 0570	
d. FULL NAME OF HOSPITAL OR INSTITUTION 210 S. Seventh		d. STREET ADDRESS (If rural, give location) 210 S. Seventh 0	

3. NAME OF DECEASED (Type or Print) a. (First) Minnie b. (Middle) Vernice c. (Last) BOONE		4. DATE OF DEATH (Month) (Day) (Year) April 21, 1953	
5. SEX female 3	6. COLOR OR RACE negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Jan. 22, 1907
9. AGE (In years last birthday) 46		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework	10b. KIND OF BUSINESS OR INDUSTRY Domestic help
11. BIRTHPLACE (City and State or Foreign Country) Elsberry, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME James Harvey		13b. MOTHER'S MAIDEN NAME Leavia Collins		14. NAME OF HUSBAND OR WIFE William Boone	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS William Boone, Elsberry, Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary arteriosclerosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Branchial ectasia		INTERVAL BETWEEN ONSET AND DEATH 2 days year	
---	--	---	--	--	--

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4201		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **4-19, 1953**, to **4-21, 1953**, that I last saw the deceased alive on **4-21, 1953**, and that death occurred at **10:54 pm.**, from the causes and on the date stated above.

23a. SIGNATURE Dr. Charles Kientz (Degree or title)		23b. ADDRESS Elsberry, Mo.		23c. DATE SIGNED 4/23/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Apr. 24, 1953		24c. NAME OF CEMETERY OR CREMATORY Burger Cemetery	
24d. LOCATION (City, town, or county) (State) RFD - Elsberry, Mo.					

DATE REC'D BY LOCAL REG. 4/30/53		REGISTRAR'S SIGNATURE Mrs. Clarence Kientz		FEDERAL DIRECTOR'S SIGNATURE Charles Kientz	
				ADDRESS Elsberry, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 4012

P. O. Address E. Cherry, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.